OHMAN FAMILY LIVING AT
BRIAR

15950 PIERCE STREET
MIDDLEFIELD, OHIO, 44062

Clinical Transformation Through Skilled Nursing: A Chronic Respiratory Case Study

EXECUTIVE SUMMARY

73-year-old male, military veteran with chronic respiratory failure as a result of COPD, OSA, and morbid obesity. Three years prior, he was admitted to a hospital for acute respiratory failure due to pneumonia. He was intubated, unable to be weaned, and eventually required a tracheostomy. He then was transferred to a SNF Vent Unit, which closed, resulting in his transfer to Ohman Family Living at Briar in Ohio, another VA accredited provider.

Ninety days after admission, the team of clinicians were able to completely wean him off the ventilator and commence discharge plans to return home to West Virginia. He was discharged not long after.

BACKGROUND

According to the physician's H&P, the patient had a trach in place for three years and had not walked or stood in that time. Prior to trach placement, patient was compliant with a BIPAP at bedtime at home.

The patient arrived with a size 6 Shiley XLT trach in place and required ventilation at night. When developing a baseline care plan, the patient expressed his goal to "have a chance to wean from the ventilator and return home."

OBJECTIVE

To help SNF patient achieve their goals to improve quality of life. Goals included: weaning from ventilator-dependent status and having the physical capacity to move and live independently at home.

SNF DIAGNOSES

J96.11- Chronic respiratory failure
E66.01- Morbid obesity
J44.9- COPD
Z99.11- Dependence of ventilator
Z93.0- Tracheostomy status
I50.9- Heart Failure
G47.33- OSA
I48.0- Atrial Fibrillation
I45.10- Right bundle branch block

THERAPY ASSESSMENT AND PROGRESSION

Patient was a 73-year-old male admitted for decreased mobility, poor endurance, and increased caregiver assistance needed for return home secondary to prolonged hospitalization and bedridden status due to complications requiring ventilation dependence.

Patient presented with marked decline in functional mobility from prior level of function due to increased sedentary behavior with use of wheelchair for mobility, increased weakness, confusion, poor endurance and balance, and increased caregiver dependence for all care and mobility. Patient was high risk for falls due to aforementioned deficits and co-morbidities. Therapy services were warranted in order to achieve maximum potential, improve safety awareness, strength, balance, and endurance, as well as overall functional independence with decreased caregiver burden for return home.

STATUS POST TRACH AND VENT REMOVAL

Patient was able to increase standing tolerance, balance, functional strength, participate in family training on mechanical lift use in home, and strategies to decrease caregiver assistance for safe completion of mobility, ADLs, and care at home. Patient was able to return home with an improved quality of life with recommended use of a mechanical lift for transfers and wheelchair mobility for short household distances.

OUTCOMES

Aggressive respiratory care was provided for the patient to help achieve his goals. A physician-led, multi-disciplinary approach was taken with occupational, physical, respiratory therapy, and nursing to achieve expressed goal to return home. This patient started tolerating a Capped Trach. Once that was achieved, we replaced his ventilator with a BIPAP and kept his trach capped with balloon deflated. He was able to tolerate his Bipap with great effect through Respiratory Lead Protocols, ABG Tracking, and Masimo remote monitoring. The patient's Trach was removed without issue by his respiratory therapist bedside.

CONCLUSION

Our SNF patient achieved their goals in improving quality of life. They successfully discharged home, across state lines, without a ventilator and with greatly improved independent function. The desire to return home motivated him to strive and hit each goal during his inpatient stay with us. He needed hope and skillful clinicians to accomplish his goal, Ohman Family Living and HNI provided that.

LEAD CARE TEAM*

Dennis Lagman, M.D.
Alex Mostoller, RT
Gidget Petronelli, RN
Anthony Livingston, PTA
Keeley Chaffee, PT
Jen Cencula, SLP
Alison Hoskin, OTR/L

** With special thanks to many additional medical personnel and support staff*